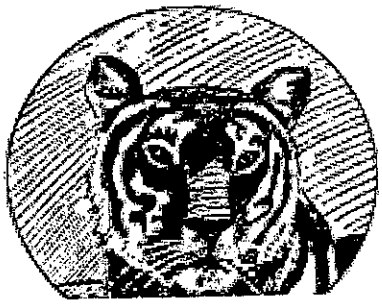
Mr. Michael Gall
Interim Superintendent
973-875-3344 ext. 315

GERARD FAZZIO
Principal
973-875-3344 ext. 314

ERIN SIIPOLA
Business Administrator/Board Secretary
973-875-3344 ext. 316
Fax: 973-875-2663



Lafayette Township Schoo

178 BEAVER RUN ROAD • LAFAYETTI
973-875-3344 • FAX: 973-875-

Thank you for your interest in registering your child in the Lafayette Township School District's Preschool program. Please find the following documents, which need to be completed and brought with you on the day of Preschool registration:

- Student Registration Form
- Home Language Survey
- Student Physical Exam Form (Universal Health form also accepted)
- Student Emergency Contact and Health Information Form
- Picture/Video Release Form
- Influenza Vaccine Form
- Getting to Know You Form
- School Health Screening Form
- Prescription Medication Administration Form
- Medication Information Form

In addition to the above completed registration forms, you must also include the following to register your child for public school within the state of New Jersey:

- A copy of your child's birth certificate
- A copy of your child's most recent immunization records
- A copy of your child's most recent physical
- 4 proofs of residency (driver's license, deed, tax bill, signed lease, utility bill, etc.)

Thank you for your prompt attention to returning these documents so we can begin the registration process. We look forward to working with you to ensure a smooth transition for both you and your child. If you have any questions or concerns, please do not hesitate to call me at 973-875-3344, ext. 6, and I will be happy to help you.

Sincerely,

Sue Webster
Secretary to the Superintendent

LAFAYETTE TOWNSHIP SCHOOL DISTRICT
178 Beaver Run Road
Lafayette, NJ 07848
Phone: (973) 875-3344 Fax: (973) 875-3066

Student Registration Form

Name: _____
Last Name First Name Middle Name

Mailing Address: _____
Street or P.O. Box

_____
Town State Zip Code

Date of Birth: _____ Age: _____ Grade: _____

Gender: M_____ F_____ Proof of Residency: _____

Birth Certificate Presented: _____ City & State of Birth: _____

Race: (Please check all with which you identify): _____Asian _____Black _____Hispanic/Latino
_____ American Indian/Alaskan Native _____ Native Hawaiian/Pacific Islander _____ White

Father's Name: _____

Phone Numbers: Home: _____ Cell: _____

Work: _____ E-Mail Address: _____

Mother's Name _____

Phone Numbers: Home: _____ Cell: _____

Work: _____ E-Mail Address: _____

Guardian name *if applicable*: _____ Phone: _____

Emergency contact other than parents: _____ Phone: _____

Any legal restrictions as to who may pick the child up from school? (Court order must be provided)

_____

Pupil Resides with: Both Parents ____ Mother Only____ Father Only____ Mother/Stepfather____

Father/Stepmother____ Legal Guardian ____ Mother/Civil Union Partner____ Father/Civil Union Partner____

Foster Care____ Grandparents ____ Parent(s) Deceased ____ Parents Separated ____

Transfer Information

School Transferred From: _____ Grade Entering: _____

School Mailing Address: _____

School Phone # _____ Transfer Date _____

Name of Preschool (for Kindergarten registrations only) _____

Transportation Information

Physical Address if different from mailing: _____
Street Name Town Zip Code

House location/describe exact location of your house: _____

Nearest Intersection _____

Student medical information (please fill in any information needed for bus driver) _____

_____

Family doctor name: _____ Dr.'s phone: _____

Day Care Arrangements: _____

_____

Sibling Information

Brothers or sisters in school:

Last Name	First Name	Middle Name	Date of Birth	M/F
Last Name	First Name	Middle Name	Date of Birth	M/F
Last Name	First Name	Middle Name	Date of Birth	M/F
Last Name	First Name	Middle Name	Date of Birth	M/F

Any history of dyslexia in the family? _____

Does your child have an IEP? _____ or a 504 Plan? _____

Date of registration: _____ Parent/Guardian Signature: _____

Required forms for registration:

_____ Affidavit of Residency – Notarized
_____ Language Survey
_____ Transfer Student – Release of Records
_____ Preschool/Kindergarten Registration – Physical Form (due at the start of school)
_____ Transfer Student – Physical Form (most recent – signed by doctor)
_____ Health History Form

Required Forms

_____ Copy of Student Birth Certificate
_____ Copy of Immunizations (most recent)
_____ Copy of Deed/Lease/Bill/Parent License etc... (4 proofs of residency required)
_____ Any Special Needs Information for IEP/504

LAFAYETTE TOWNSHIP SCHOOL DISTRICT
178 Beaver Run Road
Lafayette, NJ 07848
Phone: (973) 875-3344 Fax: (973) 875-3066

Home Language Survey*
Parent/Guardian Language Questionnaire

Directions: Fully complete and turn in with enrollment paperwork

Student Name:_____ Age:_____
[first] [middle] [last]

Date of School Entrance_____

Person completing the survey:

___ Mother ____ Father ___ Grandparent ___Guardian Other: _____

Check or write in the correct response for each of the following questions about your child.

1. What language did the child learn when he/she first began to talk?

   English___ Other [specify]_____

2. What language does the family speak at home most of the time?

   English___ Other [specify]_____

3. What language does the parent [guardian] speak to the child most of the time?

   English___ Other [specify]_____

4. What language does the child speak to his/her parent [guardian] most of the time?

   English___ other [specify]_____

5. What language does the child speak to her/her brothers and sisters most of the time?

   English___ Other [specify]_____

6. What language does the child speak to his/her friends most of the time?

   English___ other [specify]_____

Signature:_____ Date:_____
[person completing the survey]

*Adapted from the sample survey in A Manual for Community Representatives of the Title VI Steering Committee, published 9/76 by the Institute for Cultural Pluralism, Lau General Assistance Center, San Diego University, San Diego, CA 92182

LAFAYETTE TOWNSHIP SCHOOL DISTRICT
178 Beaver Run Road
Lafayette, NJ 07848
Phone: (973) 875-3344 Fax: (973) 875-3066

Encuesta del Idioma usado en el Hogar*
]Idioma de Padres/Guardianes

Instrucciones: Complete compleiamente y incluya con las olros papeles para matricularse

Nombre: ______________________________ Edad: ______________
[Nombre] [Inicial] [Apellido]

Fecha de la entrada a la escuela: __________

Persona que completa la Encuesta: [ ] Madre [ ] Padre [ ] Abuelo(a) [ ] Guardian [ ] Otro: __________

Direcciones: Selccoioue o escriba la respuesta correcta para cada una de las siguientes preguntas acerca de su hijo.

1. ¿Cual idioma aprendi6 su hijo(a) cuando empez6 a hablar por primera vez?

   Ingles: [ ] Espanol: [ ] Otro [Especifique cual]: __________

2. ¿Cual idioma se habla en su hogar la mayoria del tiempo?

   Ingles: [ ] Espanol: [ ] Otro [Especifique cual]: __________

3. ¿Cual idioma le habla usledes al nino(a) la mayoria del tiempo?

   Ingles: [ ] Espanol: [ ] Otro [Especifique cual]: __________

4. ¿Cual idioma habla el nino(a) con ustedes la mayoda del tiempo?

   Inglés: [ ] Espanol: [ ] Otro [Especifique cual]: __________

5. ¿Cual idioma le habla el nino(a) a sus hennanos(as) la mayoria del tiempo?

   Ingles: [ ] Espanol: [ ] Otro [Especifique cual]: __________

6. ¿Cual idioma habla el nino(a) a sus amigos la mayoria del tiempo?

   Ingles: [ ] Espanol: [ ] Ot1·0 [Especifique cual]: __________

Finna: ______________________ Fecha: __________

[Persona quc lleno la cncuesta]

* Adaptado de la encuesla ejemplar en A Mnin1al for Commmnily Represenlalive, ofthe Title VI Steering Commillee, publicatio en 9/76, por el Inslituto de Pluralismo Cultural, Lm General Assistance Center, San Diego University, San Diego, CA 9218

Lafayette Township School
178 Beaver Run Road, Lafayette, NJ 07848
Student Physical Examination Form

Phone 973-875-3344 Fax 973-875-3066

Student_____ Parent/Guardian Contact #_____
Date of Birth_____ Sex_____ Date of Last Medical Exam_____
Height_____ Weight_____ Blood Pressure_____

_____Ears	_____Heart	_____Skin
_____Eyes	_____Lungs	_____(non-communicable)
_____Lymph Glands	_____Abdomen	_____Nutrition
_____Thyroid	_____Hernia	_____Nervous System
_____Nose	_____Genito-Urinary	_____Speech
_____Throat	_____Orthopedic	_____Other
_____Teeth	_____Allergies	

General Comments_____
Surgery_____
Injuries_____
Disabilities_____
Activity Restrictions_____
Is this child on any medication?_____ If so, what?_____

Immunization Record – Indicate below as Day/Month/Year or attach Complete Immunization Record.
Pneumococcal (required for entrance to Pre-School only) 1._____ 2._____
Flu Shot (required for entrance to Pre-School only) 1._____
DTAP 1._____ 2._____ 3._____ 4._____ 5._____ 6._____
MMR 1._____ 2._____
Hepatitis B 1._____ 2._____ 3._____
Meningococcal _____
Polio Vaccine – Indicate Type: _____IPV or _____OPV
1._____ 2._____ 3._____ 4._____
HIB 1._____ 2._____ 3._____ 4._____
Mantoux – Date:_____ Results: _____
Lead Level – Date:_____ Results: _____
COVID-19 Vaccine:_____

Illness/Disease Record - Write *YES* or *NO* & include *DATE*

Chicken Pox_____	Pertussis_____
Rubella_____	Convulsive Disorder_____
Measles_____	Asthma_____
Mumps_____	Diabetes_____
Scarlet fever_____	Otis media_____
Rheumatic fever_____	Other_____

Physician's Name (Print)_____ Phone #_____

Examining Physician's Signature & Date_____

HCP Office Stamp (required)

LAFAYETTE TOWNSHIP SCHOOL DISTRICT
178 Beaver Run Road
Lafayette, NJ 07848
Phone: (973) 875-3344 Fax: (973) 875-3066

STUDENT EMERGENCY CONTACT & HEALTH INFORMATION

Student's Name: _____ **Male/Female:** _____ **Date of Birth:** _____
Grade:_____ **Homeroom:** _____ **City of Birth:** _____

Home Address: _____
Address City State Zip

Mailing Address: _____
Address City State Zip

Mother's Name: _____ **Resides With Student?** Yes____ No____
Address: _____
Mother's Home Phone: _____ Daytime Phone: _____
Mother's Employer: _____ Mother's Email: _____
Mother's Cell Phone: _____ **Resides With Student?** Yes____ No____

Father's Name: _____
Address: _____
Father's Home Phone: _____ Daytime Phone: _____
Father's Employer: _____ Father's Email: _____
Father's Cell Phone: _____ **Resides With Student?** Yes____ No____

Guardian's Name & Relationship: _____
Address: _____
Guardian's Home Phone: _____ Daytime Phone: _____
Guardian's Employer: _____ Guardian's Email: _____
Guardian's Cell Phone: _____

List a maximum of 5 persons who you authorize to pick up your child at any time from school.
A note from you is required for all persons whose names do NOT appear on this list.

Contract 1
Name: _____ Relationship: _____
Home Phone_____
Daytime Phone: _____ Cell Phone: _____

Contact 2
Name: _____ Relationship: _____
Home Phone: _____
Daytime Phone: _____ Cell Phone: _____

Contact 3
Name: _____ Relationship: _____
Home Phone: _____
Daytime Phone: _____ Cell Phone: _____

Contact 4
Name: _____ Relationship: _____
Home Phone: _____
Daytime Phone: _____ Cell Phone: _____

Contact 5
Name: _____ Relationship: _____
Home Phone: _____
Daytime Phone: _____ Cell Phone: _____

Student's Name: _____

Please list other children attending New Jersey Public Schools (Name, Grade, School)

_____ _____
_____ _____
_____ _____
_____ _____

Emergency Information:
Family Physician and/or Clinic Facility: _____
Address: _____
Phone: _____

All medications, including Tylenol, require written parental permission renewed annually. Prescription and non-prescription medications must be sent in the original container accompanied by the school's Prescription Medication Administration form.

I hereby give permission for the school nurse to administer acetaminophen (generic Tylenol) to my child who is not allergic to it YES_____ NO_____

My son/daughter has the following medical problems, chronic disease, or allergies:

_____

My son/daughter takes the following medication(s) on a regular basis:

_____
_____

**Information regarding my child's medical history and/or condition may be shared with school staff on a need to know basis: YES_____ NO_____

_____ _____
Parent/Guardian Signature **Date**

Insurance Information Requested By
State of New Jersey Department of Education

Does this child have Health Insurance?
YES_____ If YES, name of insurance company_____

NO_____ NJ FamilyCare provides free or low cost health insurance for uninsured children and certain low income parents. For more information and to apply to the program, call 800-701-0710 or visit www.njfamilycare.org to apply online.

Upon request by NJFamilyCare, do we have your permission to release your name and address to the NJ FamilyCare Program so that they may contact you about health insurance? If yes, please sign below. We cannot guarantee they will contact you so please call the number above or visit their website if you are interested in learning more about or applying for this program.
Written consent required pursuant to 20U.S.C. § 1232g (b)(1) and 34 C.F.R.99.30 (b).

_____ _____ _____
Signature Printed Name Date

LAFAYETTE TOWNSHIP SCHOOL DISTRICT

178 Beaver Run Road
Lafayette, NJ 07848
Phone: (973) 875-3344 Fax: (973) 875-3066

Parental/Guardian Consent Form
For Release of Student Name And/Or Picture/Video

Dear Parent /Guardian,

From time to time during the school year we take pictures and/or videos of class activities and special events for the school newspaper, yearbook, or for other classroom projects. There are also times when we are asked or choose to submit this information, along with our students' names, to the local newspapers for recognition of our school programs and students.

We would like to work with you in determining the level of consent for your child. We will not publish personally identifiable information for your child without written consent from you as parents(s) or guardian(s). The following are some examples of "personally identifiable" information: student name, photo/image, grade, residence, etc.

Please be advised that your consent will continue for the duration of your child's enrollment in the Lafayette Township School District. If you, as a parent or guardian, wish to rescind this agreement, you may do so at any time, in writing, by sending a letter to the superintendent and such action will take effect upon receipt of this request in the school's main office.

Please indicate your choice of level of consent and return the entire page to Lafayette Township School District as soon as possible. If you have more than one child, please use a separate form for each child.

Parental/Guardian Consent Form
For Release of Student Name And/Or Picture/Video

Date: _____

Student's Full Name (please print): _____ Grade_____

_____ YES: Your selection of "YES" grants your permission for Lafayette Township School administration, staff or its designees to photograph or video record your child during school sponsored events or activities with your understanding these photos, images or videos, along with your child's name, could appear in local newspapers and school publications in recognition of school programs and/or accomplishments.

_____ NO: Your selection of "NO" indicates your preference to exclude your child from having his/her picture and or video taken during school sponsored events and activities and that your child's name will not be published in any publications.

_____ _____

Parent/Guardian Signature Parent/Guardian Printed Name

Mr. MICHAEL GALL
Superintendent
973-875-3344 ext. 315

GERARD FAZZIO
Principal
973-875-3344 ext. 314

ERIN SIPOLA
Business Administrator/Board Secretary
973-875-3344 ext. 316
Fax: 973-875-2663

Lafayette Township School District

178 BEAVER RUN ROAD * LAFAYETTE, NJ 07848
973-875-3344 * FAX: 973-875-3066

Dear Families of Lafayette Township School,

According to N.J.A.C. 8:57-4, it states the following:

- ALL preschool students aged 6 months through 59 months are required by New Jersey state law to have their annual influenza vaccine.
- "The current seasonal influenza vaccine is required every year for those children 6 months through 59 months of age. Students who have not received the flu vaccine by December 31 must be excluded (not allowed to attend childcare/preschool) for the duration of influenza season (through March 31), until they receive at least one dose of the influenza vaccine or until they turn 60 months of age. Children enrolling in childcare/preschool after December 31, must provide documentation of receiving the current seasonal flu vaccine before being allowed to enter school. Students enrolling in school after March 31 are not required to receive the flu vaccine; however, flu season may extend until May and therefore getting a flu vaccine even late in the season is still protective."
- Medical and/or religious exemptions will apply when approved by the administration and/or nursing office according to N.J.A.C. 8:57-4.3; N.J.S.A. 26:1 A—9.1; and N.J.A.C. 8:57-4.4.

If your child received the influenza vaccine, please make sure that I received a copy of verification. If your child did not receive his/her vaccine, please make an appointment as soon as you can. Doctor's offices are already booking quickly for these vaccines.

Kindly,

Lillian MacRae

Getting To Know Your Child

Help me learn all I need to know to help your child have an enjoyable and successful year.

Child's Full Name_____ Date of Birth_____

Preferred Name_____

Address_____

Preferred Telephone Number to Learn_____

Father's Name_____ Occupation_____

Cell/Work #_____

Mother's Name_____ Occupation_____

Cell/Work #_____

Food Allergies_____

Medical Conditions_____

Which hand does your child prefer to use?_____

My child's favorite things:

Favorite color: _____

Favorite book: _____

Favorite toy: _____

Other favorites:_____

My child is good at: _____

_____

My child likes to: (check all that apply)

____listen to stories

____sing

____play alone

____play outside

____go to friend's house

____draw and color

____dance

____play with other children

____play quiet games inside

____play make-believe

My child doesn't like to : _____

_____

How does your child learn best? ___Touching things ___Looking at things

___Hearing things Describe_____

Some things I would like you to know about our family: (i.e. activities that you family enjoys doing together) _____

_____

_____

There are _____ children in our home. Their ages and names are:

_____

_____

_____

_____

What behaviors do you see at home? ___Tantrums ___Clinging ___Yelling

___Interrupting ___Inability to share ___Difficulty changing activities

___Difficulty cleaning up ___Hitting ___Takes direction ___Cooperates

Other Concerns _____

_____

What are your hope for you child during their preschool year?

_____

_____

_____

_____

Thank you for introducing me to you child. With your help, I know this is going to be a wonderful year!

Mr. MICHAEL GALL
Superintendent
973-875-3344 ext. 315

GERARD FAZZIO
Principal
973-875-3344 ext. 314

ERIN SIIPOLA
Business Administrator/Board Secretary
973-875-3344 ext. 316
Fax: 973-875-2663

Lafayette Township School District

178 BEAVER RUN ROAD • LAFAYETTE, NJ 07848
973-875-3344 • FAX: 973-875-3066

Dear Parent/Guardian:

The following information is needed to up-date your Child's Health Record.
Please complete and return to school as soon as possible.

Student Name_____ Grade _____

Teacher's Name_____ School Year_____

I am aware that my child will participate in the following School Health Services where applicable:

1. Vision and hearing screening
2. Height and weight
3. Blood pressure
4. Scoliosis screening-starting at age 10, to be completed every other year

_____**I wish to be present for scoliosis screening.**
_____**I decline to have the following screenings completed on my child at school:**
_____

My child was seen by his/her pediatrician on _____(date) for a physical.

If you decline screenings, **you must attach a copy of your child's physical**The physical must include: Vision and hearing screening, height and weight, blood pressure and scoliosis.

_____ _____
Signature of Parent/Guardian Date

Please fill out the following pertinent information: (Any changes from last school year)

Immunizations:_____
Allergies:_____
Surgery:_____
Injuries:_____
Medication:_____

Sincerely,

Lillian MacRae
Certified School Nurse

Mr. MICHAEL GALL
Superintendent
973-875-3344 ext. 315

GERARD FAZZIO
Principal
973-875-3344 ext. 314

ERIN SIPOLA
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Lafayette Township School District

178 BEAVER RUN ROAD • LAFAYETTE, NJ 07848
973-875-3344 • FAX: 973-875-3066

Authorization For Dispensing Medication in School:

NOTE: Whenever possible, medication should be given at home and every effort should be made to avoid school hours.

TO BE COMPLETED BY PARENT OR GUARDIAN:

I request that my child_____, grade _____receive medication in school as prescribed by his/her physician in the form below. The medication will be given to my child per Board Policy. understand that the district is rendering a service and does not assume any responsibility for this matter, I further understand that the school nurse will administer the medication.

Signature_____Parent or Guardian

Phone Number:_____ Date_____

TO BE COMPLETED BY PHYSICIAN: I request that my patient receive the following medication:

Name of Student: _____

Diagnosis: _____

Name of Medication: _____

Prescribed dosage and means of Administration: _____

Time to be taken during school hours: _____

Expected duration of treatment: _____

Possible side effects and adverse reactions: _____

Other recommendations:_____

Physician's Signature: _____ Physician Stamp:

Phone number:_____
Date: _____

Lillian MacRae
Certified School Nurse

Mr. MICHAEL GALL
Superintendent
973-875-3344 ext. 315

GERARD FAZZIO
Principal
973-875-3344 ext. 314

ERIN SIIPOLA
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Lafayette Township School District

178 BEAVER RUN ROAD • LAFAYETTE, NJ 07848
973-875-3344 • FAX: 973-875-3066

Medication Information:

The Lafayette Township School District Nurses will administer medication in school according to the State of New Jersey law.

MEDICATION GIVEN IN SCHOOL BY THE SCHOOL NURSE:

- Medication will be given in school during regular school hours only when the student's attendance depends on the timely administration of such medication. "Medication" as per this law means any prescribed drug, or over-the-counter medication including but not limited to aspirin and cough drops.
- Requests for medicating a student in school must be made in writing and signed by the student's physician.

NOTE: ALL MEDICATION MUST BE IN THE ORIGINAL PRESCRIPTION CONTAINER WITH THE PHARMACY LABEL ATTACHED.
MEDICATION CAN NOT BE EXPIRED.

IMPORTANT: PARENTAL HANDWRITTEN NOTES WILL NOT BE ACCEPTED TO ADMINISTER MEDICATION. NEW JERSEY REGULATION REQUIRES PHYSICIAN ORDERS. PARENTS MAY CALL THE PEDIATRICIAN TO FAX OR EMAIL ORDERS TO THE BUILDING NURSE.

Feel free to contact the nurse with any questions or concerns:

Sincerely,

Lillian MacRae
Certified School Nurse